Ahmad Zubir bin Zahid (suing by himself and as the administrator of the estate of Fatimah bt Samat, deceased) v Datuk Dr Zainal Abidin Abdul Hamid & Ors

COURT OF APPEAL (PUTRAJAYA) — CIVIL APPEAL NO W-02(NCVC)(W)-1087–06 OF 2017
HAMID SULTAN, ABANG ISKANDAR AND RHODZARIAH BUJANG JJCA
2 NOVEMBER 2018

Tort — Negligence — Medical negligence — Appellant filed action against respondents for professional negligence — High Court dismissed appellant's action — Application of Broad Test or Patient Autonomy Concept in Malaysia — Refusal of post-mortem when cause of death was heavily contested — Whether appellate intervention warranted

This was an appeal against the decision of the High Court who had dismissed the appellant's action. The appellant filed an action of professional negligence against the respondents for the death of his wife ('the deceased'). The deceased who had not strictly followed medical advice and appointments, had admitted herself in the hospital within the last two hours of her life. To compound the problem, the family of the deceased also refused a post-mortem which deprived the appellant the best primary evidence of the cause of death. The appellant claimed that the respondents were negligent and in breach of contract when they failed to give sufficient advice, consult the proper specialist doctor, failed to act sufficiently, failed to seek second opinion, etc.

Held, dismissing the appeal with costs:

(1) The conservative position was that a doctor's duty towards his patient was that he had to exercise a fair and reasonable standard of care and skill ie the skill of an ordinarily competent medical practitioner. The court ultimately must determine whether the doctor had acted reasonably and logically and got his facts right. In consequence medical negligence cases in Malaysia could not be decided by a medical judgement but by way of a judicial determination (see paras 13 & 20).

(2) The Malaysian court's decision do not incorporate the broad test propounded in the case of *Montgomery v Lanarkshire Health Board* [2015] UKSC 11 ('*Montgomery*'s case) case or the Patient Autonomy concept. Any cross-examination tactics based on *Montgomery* principle against the medical profession may not be within our jurisprudence. In addition, liability or quantum could not be based on principles related to

Montgomery's case (see para 24).

(3) The learned judge had taken into consideration the totality of evidence and concluded that the appellant's claim must be dismissed. In essence, the case related to finding of facts and it also did not impinge on the principles stated in *Foo Fio Na v Dr Soo Fook Mun & Anor* [2007] 1 MLJ 593, *Zulhasnimar bt Hasan Basri & Anor v Dr Kuppu Velumani P & Ors* [2017] 5 MLJ 438 and/or *Dr Hari Krishnan & Anor v Megat Noor Ishak bin Megat Ibrahim & Anor and another appeal* [2018] 3 MLJ 281, and in consequence appellate intervention was not warranted (see para 28).

[Bahasa Malaysia summary

Ini merupakan rayuan terhadap keputusan Mahkamah Tinggi yang telah mengetepikan tindakan perayu. Perayu telah memfailkan satu tindakan kecuaian profesional terhadap responden untuk kematian isterinya ('si mati'). Si mati merupakan seorang individu yang tidak mengikut secara baik nasihat dan temu janji perubatannya, beliau telah memasukkan dirinya secara sendiri ke hospital dalam masa dua jam terakhir hidupnya. Untuk membuat masalah tersebut lebih teruk, keluarga si mati telah menolak untuk membuat bedah siasat yang menghalang perayu dengan keterangan utama terbaik berkenaan dengan punca kematian. Perayu menyatakan bahawa responden cuai dan melanggar kontrak apabila mereka gagal untuk memberikan nasihat yang mencukupi, merujuk kepada doktor pakar yang sepatutnya, gagal untuk bertindak dengan mencukupi, gagal untuk mendapatkan pandangan kedua, dll.

Diputuskan, mengetepikan rayuan dengan kos:

(1) Kedudukan konservatif adalah bahawa kewajipan doktor terhadap pesakitnya adalah dia hendaklah menggunakan kewajipan berjaga-jaga dan menggunakan kemahiran yang berpatutan dan munasabah iaitu kemahiran seorang pengamal undang-undang yang biasa dan mahir. Mahkamah pada akhirnya perlu memutuskan sama ada doktor tersebut telah bertindak secara logik dan munasabah dan mendapat faktanya betul. Sebagai kesan, kes-kes kecuaian perubatan di Malaysia tidak boleh diputuskan oleh penghakiman perubatan tetapi keputusan penghakiman (lihat perenggan 13 & 20).

(2) Keputusan mahkamah Malaysia untuk tidak mengguna pakai ujian Broad yang dikemukakan dalam kes *Montgomery v Lanarkshire Health Board* [2015] UKSC 11 ('kes *Montgomery*') atau konsep kebebasan pesakit. Apa-apa taktik pemeriksaan balas berdasarkan prinsip *Montgomery* terhadap profesion perubatan tidak merupakan sebahagian daripada jurisprudens kita. Tambahan lagi, liabiliti atau kuantum tidak boleh berdasarkan prinsip berkaitan dengan kes *Montgomery* (lihat perenggan 24).

(3) Hakim terpelajar terkhilaf dalam mengambil kira keseluruhan keterangan dan memutuskan bahawa tuntutan perayu mesti diketepitkan. Secara asasnya, kes berkaitan dengan dapatan fakta dan ianya juga tidak melanggar prinsip yang dinyatakan dalam *Foo Fio Na v Dr Soo Fook Mun & Anor* [2007] 1 MLJ 593, *Zulhasnimar bt Hasan Basri & Anor v Dr Kuppu Velumani P & Ors* [2017] 5 MLJ 438 dan/atau *Dr Hari Krishnan & Anor v Megat Noor Ishak bin Megat Ibrahim & Anor and another appeal* [2018] 3 MLJ 281, dan sebagai kesan campur tangan rayuan tidak diperlukan (lihat perenggan 28).]

Notes

For cases on medical negligence, see 12(1) *Mallal's Digest* (5th Ed, 2017 Reissue) paras 1657–1676.

Cases referred to

Bolam v Friern Hospital Management Committee [1957] 2 All ER 118, QBD (refd)

Bolitho v City and Hackney Health Authority [1998] AC 232; [1997] 2 WLR 1151, HL (refd)

Dato' Dr Thuraisingam & Anor v Sanmarkan a/l Ganapathy & Anor [2016] 3 MLJ 227; [2015] 8 CLJ 248, CA (refd)

Dr Hari Krishnan & Anor v Megat Noor Ishak bin Megat Ibrahim & Anor and another appeal [2018] 3 MLJ 281; [2018] 3 CLJ 427, FC (refd)

Foo Fio Na v Dr Soo Fook Mun & Anor [2007] 1 MLJ 593; [2007] 1 CLJ 229, FC (refd)

Hii Chii Kok v Ooi Peng Jin London Lucien and another [2017] SGCA 38, CA (refd)

Kyros International Sdn Bhd v Ketua Pengarah Hasil Dalam Negeri [2013] 2 MLJ 650, CA (refd)

Montgomery v Lanarkshire Health Board [2015] UKSC 11, SC (refd)

Naxakis v Western General Hospital (1999) 197 CLR 269, HC (refd)

R v Bateman [1925] All ER Rep 45 (refd)

Rogers v Whitaker [1992] 175 CLR 479, HC (refd)

Sidaway v Board of Governors of the Bethlem Royal Hospital and the Maudsley Hospital [1985] AC 871, HL (refd)

Zulhasnimar bt Hasan Basri & Anor v Dr Kuppu Velumani P & Ors [2017] 5 MLJ 438, FC (refd)

Legislation referred to

Evidence Act 1950 s 114(g)

Federal Constitution arts 5, 8

Appeal from: Suit No 22NCVC-357–07 of 2014 (High Court, Kuala Lumpur)

Manmohan Singh Dhillon (KB Karthi with him) (PS Ranjan & Co) for the appellant.
Maidzuara Mohammed (Harish Nair with her) (Raja, Darryl & Loh) for the first and second respondents.
Felix Raj (Christina Lau with him) (Felix Raj Chambers) for the third respondent.
T Tharumarajah (Amos Siew with him) (Azim Tunku Farik & Wong) for the fourth respondent.

Hamid Sultan JCA (delivering judgment of the court):

[1] The appellant/plaintiff (the husband of the deceased) who had filed an action in professional negligence against the defendants for the death of the deceased, appeals against the decision of the learned High Court judge who had dismissed the action.

PRELIMINARIES

[2] This is a unique case in medical negligence related to a strong willed deceased. The deceased who had not strictly followed medical advice and appointments, had admitted herself in the hospital in the last leg of her life and that too within one or two hours. Notwithstanding some preliminary professional assistance was provided, had died. To compound the problem, the family of the deceased also had refused a post-mortem on the deceased. This had actually deprived the plaintiff the best primary evidence of the cause of death. On the facts of the instance case, best evidence would have given a greater probative force than all the expert evidence.

[3] It must be noted that the development of case laws in medical negligence which lean heavily towards patient care as opposed to the principles stated in *Bolam v Friern Hospital Management Committee* [1957] 2 All ER 118 had given a full load of armoury for a claimant in medical negligent case literally to plead and cross-examine witnesses in a harsh manner to secure a monetary compensation. In that process, the dignity and integrity of professional in essential service may be blemished and/or destroyed. Due to the development of case laws in other jurisdiction, it is now in a sad state of affairs and need statutory intervention. We will elaborate on this further.

[4] On the date of hearing of this appeal, the learned counsel for the appellant requested a two day hearing, for a claim where the monetary sum may be about RM1m only and that too in an area of tort where the judicial principles are well settled. We took the view that: (a) it was unreasonable for the appellant to seek a two day hearing on the date of appeal on such matters; (b) judicial time must be proportionately spend in public interest; and (c) if the case raises a point of public interest as opposed to general principles of law, then

A the time of hearing should be sorted out at the case management stage or request made to the President of the Court of Appeal, for a longer hearing.

[5] We informed the counsel that we have already read the appeal records and the submissions that the parties have filed earlier and the bench took the view that a time allotment of 30 minutes per party will be sufficient to highlight the issues involved. We also informed the parties that we want further submission on the effect of the failure to do the post-mortem as the cause of death was not strictly established due to such failure. For that purpose, we had agreed to give parties time for further written submission.

[6] Parties, after the hearing, have filed further submissions. We have read them and will now deliver our judgment.

[7] It must be noted that the first respondent's role was one of consultant and he was not at the scene when the deceased died. The second respondent's role was in respect of preliminary attendance. The complaint against the hospital is related to lack of professionalism in patient care. The learned trial judge had dealt with each and every complaint as well as the strength of the medical evidence. In essence, His Lordship, in our own words, took the view that it was a trumped-up claim which was also not rooted in law and dismissed it with a total costs of RM250,000. The trial itself had taken a phase of more than one and half year, with a number of professional medical witnesses for the plaintiff as well as the defendants.

BRIEF FACTS

[8] In the instant case, the learned trial judge had written a meticulous judgment setting out the facts and law in a simple and lucid manner, making the judgment a class of its own to demonstrate the judge's ability to write a speaking judgment as well as a learned judgment. This judgment must be read with the said judgment to appreciate the facts and law.

[9] The case principally involves issues related to medical advice and treatment and the extent of duty of care as well as liability of hospitals in providing the professional services. To save court's judicial time, we repeat the facts of the case and the decision of the court as placed before us in a rudimentary manner. It read as follows:

(1) The plaintiff/appellant/P1 is suing in his personal capacity and as the administrator for his wife/the deceased/DC. DC died at Pantai Medical Centre (PMC) on 9.10.2012. The causes of action are medical negligence and breach of contract. The defendants/respondents are; D1 a consultant cardiologist of PMC, D2 a senior medical officer of Institut Jantung

Negara (IJN), D3 a company that owned and managed PMC, and D4 a company that owned and managed IJN.

(2) DC first saw D1 in 2002 at IJN. DC informed D1 that she had mitral valve replacement in 1998. DC was pregnant in 2011 but the pregnancy was terminated due to death of the fetus. About 6 months before her death ie on 21.3.2012, DC saw D1 for follow up appointment. DC informed D1 she wanted to get pregnant again via frozen egg transfer. DC's fertility doctor told DC to switch from Warfarin blood thinner medication to Clexane. DC wanted to take Clexane as advised.

(3) On the next day ie on 22.3.2012, D1 advised DC to be prescribed for Clexane for 0.4 ml and Warfarin 3 mg to be taken daily if DC got pregnant. About a month afterwards ie on 19.4.2012, DC informed D1 that she was pregnant. D1 observed that DC's vital signs were normal. D1 advised DC to take Casprin blood thinner for second trimester of her pregnancy and an ECHO be done at her next appointment.

(4) On 31.5.2012, DC was at 12 weeks gestation. DC informed D1 that she had bad morning sickness but it was now better. D1 also had shortness of breath but not as bad as the 1st pregnancy. DC still taking Clexane at this time. DC's blood pressure and pulse are within normal range.

(5) On 28.6.2012, DC was at 16 weeks gestation. DC complained about her palpitations if DC lied on her right side. DC had no shortness of breath on exertion. DC still taking Clexane. No significant findings. On 26.7.2012, DC had a loss of appetite. No other significant findings. On 6.9.2012, no significant findings. The next appointment was fixed to Dr Azar and Dato' Dr Sanjiv as they were available for consultation.

(6) On 26.9.2012, DC sent an SMS to D1 that she got swollen feet but no chest pain. On 27.9.2012, DC went to see Dr Raman who testified that DC only complained about getting tired and she was happy and in good spirits. On 1.10.2012, DC sent another SMS to D1 that DC had shortness of breath, light headedness and numbness etc. and DC would like to have another appointment. D1 called DC and arranged an appointment with Dato' Dr Sanjiv on 6.10.2012. DC did not show up but requested a new appointment on 13.10.2012.

(7) However, on 8.10.2012 ie 1 day before her death, DC sent an SMS to D1 requesting to be admitted to PMC as she felt tired, shortness of breath and chest pain. D1 then called DC to go to emergency at IJN or PMC. DC did not want to be admitted and wanted to see D1's colleague, Dr Azar, on 10.10.2012.

(8) On 9.10.2012, the day that DC died, DC went to IJN about 2.30 am as she was seen by D2. DC gave her medical history to D2. She was still on Clexane. D2 examined DC that she had normal functioning mitral valve with a fast heart beat consistent with pregnancy. D2 advised DC to continue with Clexane. On 7.40 pm on the same day, DC went to PMC Emergency Department. After triage assessment was performed by nurses at 7.45 pm, DC was breathless and hyperventilating.

(9) SD3 stationed at the PMC Emergency Department. SD3 ordered ECG be made to DC. SD3 then called D1 upon receiving the ECG result. Haziness was detected in the lower part of both DC's lungs. D1 instructed SD3 to transfer DC to Dr Azar at ICU. Dr Azar saw DC at 9.30 pm. DC passed away at 10.40 pm. The cause of death was certified as 'Acute Pulmonary Oedema Secondary to Prosthetic Valve Malfunction'. Pi as the husband refused post mortem be done on DC.

(10) P1 claimed that; the defendants/DD were negligence and in breach of contract among others; failed to give sufficient advice, failed to consult to the proper specialist doctor, failed to act sufficiently, failed to seek second opinion etc. Special Damages claimed by P1 are medical expenses, funeral expenses, costs to obtain letter of administration, costs of obtaining medical records, travelling expenses and loss of contribution for RM570.823.90.

(11) P1 prayed for: General Damages including bereavement. Special Damages of RM570323.90. Costs and other suitable relief.

(12) The defendants/DD stated that: DD denied all the claim.

(13) High Court: PTs claim is dismissed with costs of RM150,000 to R1&R2, RM50,000 to R3 and RM50,000 to R4.
Grounds of Decision of High Court
Whether P1 could prove his claim on the balance of probability.

(14) The court accepted the principle in *Bolam*'s case that P1 has to prove that D1 had not acted in accordance with the accepted practise expected of him as Consultant Cardiologist. The absence of post mortem and differing opinion left the court unable to determine the most probable cause of death without embarking on a guessing exercise.

(15) DC declined Warfarin as she believed that was the cause of the death in the first pregnancy. D1 had discharged his duty of care in advising DC. A doctor could not diagnose Pulmonary Hypertension with just the ECHO reading. Mostly, P1 is claiming that another test or another specialist or another system could have save DC where DD should not be faulted for not doing so. P1 failed to prove all the claims against DD.

[10] The memorandum of appeal of the appellant read as follows:

1. That, in this medical negligence case, the learned trial Judge had failed to apply correctly, sufficiently or at all the legal principles concerning:

1.1. the application or non-application, as dictated by the circumstances, of the *Bolam* test;

1.2. the standard of care expected of doctors in matters of diagnosis and treatment;

1.3. the patient-centred test in regard to a doctor's duty to give advice and information to a patient, especially on the risks and benefits of each treatment option;

1.4. the assessment of expert evidence;

1.5. causation of damage, including the doctrine of material contribution to an indivisible injury or to damage;

1.6. the point that the standard of proof is not a scientific standard;

1.7. reasonable foreseeability of damage;

1.8. the direct liability of the owners and managers of hospitals, as providers of healthcare, for breach of their non-delegable duty of care;

1.9. the vicarious liability of the owners and managers for the negligence in their hospitals of healthcare practitioners, including nurses, medical officers, specialists and consultants;

1.10. false or misleading pleading; and

1.11. the eventually unsuccessful suppression of relevant evidence showing lack of care;

The Bolam Test and the Bolitho Qualification to It

2.that the learned trial Judge had erred in applying the *Bolam* test to certain aspects of the case when it was not relevant;

3. that the learned trial Judge had erred in applying the *Bolam* test to aspect of the case:

3.1. which did not involve the exercise of professional skill and judgment; and/or

3.2. which required compliance by the Respondents with their contractual obligations and/or statutory duties;

4. that, when applying the *Bolam* test, the learned trial Judge had failed sufficiently or at all to apply the *Bolitho* qualification to it.

Bolam Test Not Relevant as Regards Causation of Damage

5. that the learned trial Judge had failed to recognise sufficiently or at all that the *Bolam* test has no relevance to the issue of causation of damage;

Failure to Give Advice and Information Regarding Material Risks and Benefits of Treatment

6. that the *Bolam* test does not apply to the duty to give advice and information to patients regarding the risks and benefits of each treatment option;

7. that the learned trial Judge had not addressed the issue of the Respondents failing to give to the deceased advice and information regarding the material risks and benefits of each of the treatment options;

8. that the learned trial Judge had erred in deciding in effect that such issue should not be decided because the deceased was not available to give evidence;

9. that the learned trial Judge had erred in deciding in effect that no breach of the duty of care to give such advice and information to a patient could be proven if the patient had died before trial;

10. that the learned trial Judge had given no regard to the point that the prudent patient test as regards such duty does not cease to exist if the patient concerned had died before he or she could give evidence;

No Standard of Scientific Proof

11. that the learned trial Judge had failed to apply sufficiently or at all the principles of causation of damage;

12. that the learned trial Judge had not directed himself as regards there being no standard of scientific proof in this case, including regarding the medical and expert evidence;

Death Certificate

13. that the learned trial Judge had failed to reject a certificate of death which was issued by a doctor who had not attended at all to the deceased;

14. that there was non-compliance with the provisions of the Births and Deaths Registration Act 1957, including s 22(1) thereof;

15. further or alternatively, that the learned trial Judge had failed to take any or sufficient account of the evidence, factual and expert, showing that the Respondents and their servants or agents had materially contributed to the death of the deceased,

Hearsay

16. that the learned trial Judge had failed to apply the rule against hearsay to the contents of the death certificate, which was a Part B document and the maker of which had not testified to its contents.

Onus of Proof

17. that the learned trial Judge had erred:

17.1. as regards the party on whom the onus of proof lay; and

17.2. by relying on the onus of proof, including regarding proof of the cause of death, although there was sufficient evidence for making findings of fact in favour of the Appellant;

Burden of Proof or Contents or Death Certificate

18. that the Respondents had not discharged the burden of proof of the truth of the contents of the death certificate when they relied upon it;

19. that the learned trial Judge had erred in deciding that the cause of the death of the deceased could not be ascertained by the Court because no postmortem examination had been undertaken;

20. that the learned trial Judge had erred in failing to decide that the legal onus was on the Respondents, and not the Appellant, to seek a post-mortem examination;

21. that the learned trial Judge had erred in not recognising that there was no legal right vested in the Appellant, as the next of kin of the deceased, to stop such an examination from being undertaken;

22. that the learned trial Judge had failed to decide:-

22.1. that the Respondents had acted contrary to law by relying on the Appellant's wishes against a post-mortem examination being undertaken;

22.2. that the Respondents were mistaken in thinking that the Appellant had the power to stop such an examination from being undertaken;

22.3. that the Respondents had not given the Appellant proper advice and information regarding the question as to whether such an examination should be undertaken;

22.4. that a proper interpretation to ss 328–341 of the Criminal Procedure Code did not give the Appellant the right of refusal to such an examination;

22.5. that, in the absence of a post-mortem examination and of a valid death certificate, the duty of the Court was to apply the best evidence rule as set out in the Evidence Act 1950 and at common law, including by weighing the evidence of the medical and expert witnesses; and

22.6. that, in this case, there was no need for a post-mortem examination when, in many civil and criminal cases, including of missing or unavailable dead bodies, no such examination had been undertaken but the causes of death were proven in court pursuant to the best evidence rule;

Expert Evidence and Law Evidence

23. that the learned trial Judge had erred in not giving sufficient or any weight to the common ground between the experts on both sides and which was sufficient to establish liability and causation of reasonably foreseeable damage;

24. that the learned trial Judge had failed to give sufficient or any weight to:-

24.1. the admissions of fact and/or opinion made by the Respondents and their expert and lay witnesses; and

24.2. the criticisms made by both the Appellant's experts and the Respondents' experts and the admissions made regarding various material aspects of the treatment given to the deceased, including as regards the delay in giving the necessary treatment, and the failure to undertake necessary investigations and procedures without delay;

25. that the learned trial Judge had failed to give any regard at all to the provisions of ss 46 and 51 of the Evidence Act 1950, which respectively require the weighing by the Court of the grounds for an opinion and the facts supporting or not supporting an opinion;

Findings of Fact and the Drawing of Inferences

26. that the findings of fact made were against the weight of the evidence;

27. that there was a failure to make necessary findings of fact and to draw proper inferences from the findings of fact;

Insufficient Judicial Appreciation of Evidence

28. that there had been insufficient judicial appreciation of the evidence;

Suppression of Evidence

29. that the learned trial Judge had failed to give sufficient or any weight to the eventually unsuccessful suppression of material evidence by the 1st Respondent;

False and Misleading Defence

30. that the learned trial Judge had failed to give sufficient or any weight to the misleading part of the first Respondent's Defence by which he had pleaded that he was out of the country at a time when the deceased needed and sought from him

urgent medical attention but admitted, after a number of attempts on his part to hide the truth before and during the trial, that he was in fact in Kuala Lumpur at the time.

System Failures Amounting to Negligence

31. that the learned trial Judge had failed to give sufficient or any weight to the unchallenged evidence showing system failures amounting to negligence in the hospitals concerned.

Incomplete Judgment

32. that the learned trial Judge, when dismissing the Appellant's claim, gave an incomplete judgment in that various issues of law and fact presented on behalf of the Appellant were not given sufficient or any consideration; and

Quantum

33. that the learned trial Judge had failed to give a decision on quantum.

THE JURISPRUDENCE RELATED TO MEDICAL NEGLIGENCE, ADVICE, TREATMENT AND LIABILITY OF HOSPITAL

[11] The law on medical negligence is related to evolutionary jurisprudence. The courts in common law jurisdiction have been, by virtue of judicial pronouncements, increasing the liability of doctors in favour of patients. Such an approach may be correct in countries like England and Australia where the courts are allowed to dictate the common law principles from time to time. That privilege is not vested in a country where the Constitution has vested the powers of legislation making process to Parliament. Usurping Parliamentary process and increasing liability of doctors may not be a fair procedure pursuant to rule of law as envisaged by the Federal Constitution. It may also impinge on arts 5 and 8 of the Federal Constitution. Thus, Malaysian courts have been careful in adopting any wide proposition which may impinge on medical profession (see *Dato' Dr Thuraisingam & Anor v Sanmarkan a/l Ganapathy & Anor* [2016] 3 MLJ 227; [2015] 8 CLJ 248).

[12] Leaving aside the jurisprudence mentioned above, the law on medical negligence has been an evolutionary process and courts lean towards the English and Australian decisions to dignify the law making process. The jurisprudence related to medical negligence had been captured in the case of *Dato' Dr V Thuraisingam* where the coram consisted of Hamid Sultan Abu Backer JCA, Badariah bt Sahamid JCA and Prasad Sandosham Abraham JCA. We will not set out the jurisprudence stated, save to outline the evolutionary development here in a rudimentary form.

[13] The issues on standard of care are often related to diagnosis, treatment and advice. The law on medical negligence and its application is often difficult, as facts and circumstances are not the same in each case and it varies from case

to case. The conservative position is that a doctor's duty towards his patient is that he has to exercise a fair and reasonable standard of care and skill, ie the skill of an ordinarily competent medical practitioner (*R v Bateman* [1925] All ER Rep 45). This proposition is reflected in *Bolam*'s case.

[14] The *Bolam* test propounded in 1957, had dominated the Commonwealth countries for quite some time. It deals with diagnosis, treatment and advice in a lump form to ascertain standard of care to make the doctor liable or negate liability. *Bolam*'s case in essence, did not permit the court to find the doctor's negligent in preference to one body of distinguished professional opinion to another. The *Bolam*'s case placed a high threshold on the plaintiff to establish negligence when the defence could demonstrate differing medical opinion on the issue. *Bolam* test was related to medical determination and not judicial determination on the issue of standard of care.

[15] An attempt was made as early as 1985 to increase the liability of doctors. In *Sidaway v Board of Governors of the Bethlem Royal Hospital and the Maudsley Hospital* [1985] AC 871, by majority, *Bolam* Test was accepted and it also rejected the proposition related to the duty to advise of the risk involved in a particular treatment.

[16] A successful attempt was made to increase the doctors' liability in 1997. In *Bolitho v City and Hackney Health Authority* [1998] AC 232; [1997] 2 WLR 1151 (HL), the court qualified the *Bolam* principle to say that it is not the number of experts by the defence which should determine the issue but it is for the judge to consider the evidence. By *Bolitho*'s principle, the conduct of doctors as well as the opinion is subject to judicial scrutiny and the judge has to apply common sense to come to a just conclusion and it cannot be achieved by a mechanical process in the guise of medical judgment or determination.

[17] The shocking news for doctors arrived through the decision of an Australian case (see *Rogers v Whitaker* [1992] 175 CLR 479 (*Whitaker*)). The *Whitaker*'s case attempts to extend the duty of care principle between the doctor and patient to new heights, to the detriment of the doctors and giving protection for the patients, of the right to be informed of the risks involved.

[18] Further, assault on the medical profession was made through the Australian case of *Naxakis v Western General Hospital* (1999) 197 CLR 269. *Naxakis*'s case extended *Whitaker*'s principle and compromised the principle stated in *Bolam* in totality. The court extended the principle of *Whitaker*'s case in relation to the duty to advise, to the realm of diagnosis and treatment.

[19] Following from the above decisions, the Supreme Court of England in *Montgomery v Lanarkshire Health Board* [2015] UKSC 11, extended the scope

of responsibility of doctors to focus on what is said to be a 'patient centred test' or 'prudent patient test'. The law now requires a doctor to take reasonable care to ensure that the patient is aware of any material risks involved in any recommended treatment, and of any reasonable alternative or variant treatments. This 'broad test' virtually has placed doctors as well as experts to be severely cross-examined with a view to discredit their evidence and to establish liability as well as quantum. An experience counsel for the plaintiff can virtually through cross-examination tactics, be able to conquer the 'broad test' expounded by the courts. The reason is that 'broad test' is generic in nature and has no confined parameters as to what the medical profession should do or should not do. In addition, to satisfy the criteria for the 'broad test', the costs of treatment will be multifold as well as professional indemnity insurance for doctors may also increase.

[20] The *Bolam's* case as well as *Rogers'* cases were considered by the Federal Court in the case of *Foo Fio Na v Dr Soo Fook Mun & Anor* [2007] 1 MLJ 593; [2007] 1 CLJ 229. The Federal Court did not reject the *Bolam* principle or *Whitaker*'s principle in toto but added a rider, ie to say that the court ultimately must determine whether the doctor acted reasonably and logically and got his facts right. In consequence, medical negligence cases in Malaysia could not be decided by medical judgment, but it has to be by way of judicial determination.

[21] Further, the Federal Court in *Zulhasnimar bt Hasan Basri & Anor v Dr Kuppu Velumani P & Ors* [2017] 5 MLJ 438 accepted *Whitacker*'s case and *Foo Fio Na* with regards to standard of care. However, the Federal Court confirmed that it is extended only to advise of risks associated with any proposed treatment and does not extend to diagnosis and treatment in that *Bolam*'s case is still applicable but subject to the qualification as stated in *Bolitho*'s case.

[22] In addition, the Federal Court in *Dr Hari Krishnan & Anor v Megat Noor Ishak bin Megat Ibrahim & Anor and another appeal* [2018] 3 CLJ 427, confirmed what was said in *Zulhasnimar's* case and in an unprecedented manner held that aggravated damages may also be awarded. The relevant part of the Federal Court's decision read as follows:

> (1) Although the High Court judgment in the instant case was a non-speaking one, it did not follow that a retrial or a rehearing should be ordered. Further, since the appeal was heard and disposed of by three judges on the panel of the Court of Appeal, the requirements of s 38 of the Courts of Judicature Act 1964 ('the CJA') were met. The unanimous judgment of the Court of Appeal had already been delivered orally in open court and in the presence of all three judges, thus s 42(1) of the CJA did not apply. In the circumstances, the judgment of the Court of Appeal was valid. In view that the Court of Appeal was validly constituted at the time the judgment was delivered on the appeal, the fact that two of the three panel members had retired at the time the written grounds of judgment

were subsequently given, was a non-issue. Appellate courts are advised to avoid ordering a retrial merely on account of a non-speaking judgment by a trial judge or the absence of any finding of fact on a particular issue. The statutory requirements for a retrial had not been established and thus a retrial or a rehearing was not warranted. (paras 38–54)

(2) The case of *Rogers v Whitaker*, which was followed in *Foo Fio Na*, in regard to the standard of care in medical negligence, is restricted only to the duty to advise of risks associated with any proposed treatment; it does not extend to diagnosis and treatment. With regard to the standard of care for diagnosis and treatment, the *Bolam* test still applies subject to qualifications as stated in *Bolitho.* The *Bolam* test is essentially a 'doctor knows best' test. As long as there are two conflicting views on the acceptable medical practice, and the defendant doctor acted based on one of the conflicting views, he would be exonerated from liability. In short, the standard of care is decided by the medical profession. The *Bolitho* test is the extension of the *Bolam* test, which calls upon the court to analyse the logic and reasonableness of the conflicting medical opinion advanced by the defence before accepting the same. (paras 61–63)

(3) The duty to explain risks is specific in nature; the consent form, signed by the plaintiff prior to the operation and relied upon by Dr Hari and Dr Namazie, only contained general precautions that the operation involved risks. Neither Dr Hari nor Dr Namazie had warned the plaintiff of the risks of bucking and blindness at any material time. A reasonable person in the patient's position would be likely to attach significance to it. In relation to this particular patient, given that the plaintiff had previously requested for scans to be conducted and enquired on the need for the operation, it was apparent that the plaintiff would attach significance to warnings of such risks. As such, such risks were considered to be material risks in the second operation. The duty had been breached by Dr Hari and Dr Namazie. They were therefore negligent and had deprived the plaintiff of the chance to make an informed decision as to whether to proceed with the operation or otherwise. (paras 74–76)

(4) Both the plaintiff's expert (SP4) and Dr Hari's expert (SD4) agreed that the second operation would only be necessary if there was retinal detachment. However, contemporaneous documents and testimonies of witnesses showed that there was no retinal detachment. In view thereof, Dr Hari failed to establish that he had acted in accordance with a practice accepted as proper and responsible by a responsible body of medical practitioners skilled in that particular art, in diagnosing that the plaintiff's condition required the second operation. Thus, the *Bolam* test was not satisfied and accordingly, Dr Hari was negligent when he subjected the plaintiff to an unnecessary operation, which ultimately caused the plaintiff to lose his eyesight. Dr Hari also failed to produce any evidence to show that the procedure he adopted when the SCH occurred was in accordance with the practice accepted by a responsible body of medical practitioners. As such, the *Bolam* test was not satisfied on the facts and Dr

Hari was negligent in the choice of procedure adopted in treating the plaintiff. (paras 78–81)

(5) In respect of Dr Namazie's treatment of the plaintiff, the anaesthetist was negligent in failing to keep the plaintiff anaesthetised completely during the second operation. Applying the *Bolam* test, Dr Namazie did not produce any evidence to show that his failure to ensure that the plaintiff did not buck during the second operation was supported by a body of responsible medical opinion. The plaintiff had bucked during the second operation because the plaintiff was not anaesthetised completely. The bucking could have been avoided and controlled by additional drugs. In view of the evidence, the top up dose administered on the plaintiff was clearly mistimed. Therefore, the doctors' appeal on liability was dismissed. Applying the relevant tests as clarified in the case of *Zulhasnimar Hasan Basri &Anor v Dr Kuppu Velumani P & Ors*, both Dr Hari and Dr Namazie were negligent in their advice of risks, diagnosis and treatment of the plaintiff. (paras 82–85)

(6) Aggravated damages could and had been awarded as a separate head of damage in tort (*Mohd Ridzwan Abdul Razak v Asmah Hj Mohd Nor*; refd). Aggravated damages are frequently awarded in defamation cases for injury to a person's reputation; hence there was no reason to exclude this kind of damages from medical negligence cases, which involve real injury to a person's body. In the circumstances, the second question was answered in the negative. As such, the doctors' appeal on quantum was dismissed. (para 99)

(7) Where the doctor is ascertained to be a truly independent contractor in the circumstances, the private hospital could not be held vicariously liable for the sole negligence of that doctor. The true relationship between a private hospital and a doctor practising therein must be determined from the relevant contractual terms and the factual circumstances of the case. The answer to the question posed in the hospital's appeal was therefore in the negative. From the entire sequence of events, Dr Hari's diagnosis of the plaintiff's condition, advice to undergo the second operation and conduct of the second operation were done in the course of Dr Hari's private practice. There was no evidence that the hospital exerted any control over Dr Hari's advice and conduct of the second operation, which was attributable to his own recognisably independent business. The mere change in location to the hospital for the follow up appointments and the use of the hospital's facilities in conducting the second operation, did not change the independent nature of Dr Hari's business in his treatment of the plaintiff. The structure of fees was also not indicative of a contract of service between employers and employees: Dr Hari charges his own fees to his patients and was required to pay fees for using the hospital's facilities and services. The hospital's role in collecting the patient's fees and remitting them to Dr Hari was administrative in nature. Dr Hari's advice and conduct of the second operation were not done on behalf of the hospital, and was not a part of the hospital's business activity. Dr Hari was indeed acting in the capacity of an independent contractor and not an

employee of the hospital. As such, no vicarious liability could be imposed on the hospital for Dr Hari's negligence. (paras 119–122)

(8) Dr Namazie was a visiting consultant to the hospital and was requested to provide his services to the hospital by the latter's medical director on a temporary basis. The management of the hospital did not interfere with Dr Namazie's work. In addition, he was not paid by the hospital for the services he rendered. The fees for his services were paid by the patient to Dr Namazie through the hospital, and the hospital's role in collecting the fees was purely a matter of administrative convenience. These factors were characteristic of a contract for services with independent contractors, rather than a relationship of employment. Accordingly, the hospital was not vicariously liable for the negligence of Dr Namazie in the second operation. (paras 123–126)

(9) Where a hospital is held to owe a non-delegable duty to its patient to ensure that reasonable care is taken in his treatment, the hospital may be held liable to the patient if the duty is breached, regardless to whom performance of that duty is delegated. Applying the case of *Woodland v Essex County Council* ('Woodland') to the present case, it was indubitable that the plaintiff, as a patient admitted in the hospital for the second operation, fell into the category of especially vulnerable persons and was dependent on the hospital for protection. The plaintiff was undoubtedly placed in the hospital's custody or care upon admission for the purposes of the second operation. The role of the hospital was confined to providing the necessary facilities and services for the second operation. As far as the plaintiff was concerned, the plaintiff was dependent on the hospital for the facilities and services indispensable for the second operation, including anaesthetic services. It was unchallenged that Dr Namazie was requested by the hospital to provide his anaesthetic services at the material time and the plaintiff was left with no choice of anaesthetist for the second operation. The hospital had delegated to Dr Namazie the responsibility to administer doses properly so as to keep the plaintiff anaesthetised throughout the second operation. This was an integral part of the positive duty assumed by the hospital to the plaintiff to ensure that care was taken in the provision of anaesthetic services. Dr Namazie was negligent in the performance of the duty delegated by the hospital to him, in mistiming the top up dose and thereby causing the plaintiff to regain consciousness and buck during the second operation. Therefore, applying the principles in *Woodland*, the hospital owed a non-delegable duty to the plaintiff to ensure that reasonable care was taken in the anaesthetic services provided, and the hospital was liable for the breach of this duty. Thus, the hospital's appeal was dismissed. (paras 127–140)

(10) The law on vicarious liability and non-delegable duty is an ongoing development. This court took heed of the proviso in *Woodland* to 'proceed with caution, incrementally by analogy with existing categories, and consistently with some underlying principle' and to impose liability 'only in so far as it would be fair, just and reasonable'. To make a broad announcement on the liability of all private hospitals in medical

A negligence cases on the basis of policy alone would risk over-generalising the nuances of modern business relationships, and result in an unprincipled approach to liability.

B **[23]** The courts in Singapore which had traditionally accepted *Bolam* principles have also now moved without any legislative amendments to support its decision to subscribe to what is referred to as 'patient autonomy test' (see *Hii Chii Kok v Ooi Peng Jin London Lucien and another* [2017] SGCA 38). The court had set out a modified *Montgomery* test which can be summarised as follows:

C The modified *Montgomery* test proceeds in stages as follows:

(a) The patient must identify the exact nature of the information that he alleges was not given to him.

D (b) The patient must establish why it would be regarded as relevant and material from his own perspective.

(c) The doctor must have been in possession of that information.

(d) The court must consider why the doctor chose to withhold the information from the patient from the doctor's perspective.

E (e) Whether it was justifiable for doctor to do so.

The instances of waiver by patient are as follows:

(i) When patient informs the doctor he wish not to hear further information about the proposed treatment or alternatives.

F (ii) When treatment was provided on an emergency basis.

(See *Medical Negligence and Malpractice in Singapore* — updated as per 2310–2017).

G **[24]** It is important to appreciate that the Malaysian courts' decision do not incorporate the broad test propounded in *Montgomery*'s case or the 'Patient Autonomy' concept. *Montgomery*'s case opens the door to robust pleadings as well as harsh cross-examination tactics which will lengthen trial process as can

H be garnered in the instant case. Any cross-examination tactics based on *Montgomery* Principle against the medical profession may not be within our jurisprudence. In addition, liability as well as quantum cannot be based on principles related to *Montgomery*'s case. The law on medical negligence in Malaysia needs appropriate legislative intervention to provide proper

I safeguards for patients as well as doctors.

CONCLUSION

[25] We have read the appeal records and the able submissions of the parties. After giving much consideration to the submissions of the learned counsel for the appellant, we take the view that the appeal must be dismissed.

[26] After having gone through the submissions of the parties and reading the judgment of the learned judge, we do not think the judgment as well as the decision to dismiss the plaintiffs claim is plainly wrong to warrant appellate intervention.

[27] In the further submission as requested by the court, the learned counsel of the appellant says:

> The cause of death is irrelevant. The fact that no post-mortem examination was undertaken is also irrelevant.

[28] We do not think so when the appellant themselves have refused the post-mortem and the issue in respect cause of death and medical negligence was heavily contested and the learned judge had made a finding on these issues. It may have been different if the post-mortem report was made available. The failure to allow post-mortem may attract s 114(g) of the Evidence Act 1950. However, we do not wish to dwell on this area of jurisprudence as we take the view that the learned judge had taken into consideration the totality of evidence and came to a conclusion that the plaintiff's claim must be dismissed. In essence, the case relates to finding of facts and it also does not impinge on the principles stated in *Foo Fio Na, Zulhasnimar* and/or *Dr Hari Krishnan*, and in consequence appellate intervention in our view, is not warranted (see *Kyros International Sdn Bhd v Ketua Pengarah Hasil Dalam Negeri* [2013] 2 MLJ 650).

[29] For the reasons stated above, the appeal is dismissed with costs. Deposit is to be refunded.

We hereby order so.

Appeal dismissed with costs.

Reported by Izzat Fauzan